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NO. 91-674

UNITED STATES SUPREME COURT

OCTOBER TERM, 1991

Chaves County Home Health Services, Inc., et al.

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v.

Louis W. Sullivan, M.D.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA CIRCUIT

REPLY TO RESPONDENT'S OPPOSITION

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The critical importance of the issues presented to the Court is recognized by both parties and amici. Petitioners assert that Medicare beneficiaries, providers of care, and the Medicare system itself face great harm if the Secretary is allowed to substitute sample adjudication of claims for the Congressionally mandated and traditionally utilized system of individual claims review.

Amici, representing the national interests of virtually every element of health care -- physicians, hospitals, therapists, nursing facilities, and home health care providers -- forcefully outline the grievous harm that is inflicted through sample adjudication. Uniformly these provider groups express that sample adjudication deters them from providing needed care to Medicare beneficiaries, subjects them to severe financial damage, and eliminates rights guaranteed by statute including a meaningful opportunity for relief on appeal.

Respondent contends that the use of sample adjudication is crucial to the operation of the Medicare program. Accordingly, all parties agree that the issues presented in this petition are of vital importance to Medicare and the health care system.

Accordingly, there is no dispute that this case involves an important issue of federal law of major significance to Respondent, as well as the entire health care community. Rule 10.1(c) of the U.S. Supreme Court.

ARGUMENT

The Brief For The Respondent In Opposition raises serious issues which necessitate this reply. Respondent has mischaracterized the issues in this case, obscured the unfairness of sample adjudication, and misstated the longstanding practice and process of claims adjudication.

A. Individualized coverage determinations must precede the Medicare overpayment recoupment process.

This matter concerns exclusively the process of coverage determinations for claims submitted to the Medicare program under 42 U.S.C. § 1395ff(a). It does not involve, as claimed by the Respondent, the power and process to recoup alleged Medicare overpayments after a lawful coverage determination has been issued.[1] Likewise, the reasonableness of sampling in the abstract context is not challenged. Instead, the core issue is whether Respondent's sample adjudication policy conflicts with the minimum statutory due process requirements for making coverage determinations in Medicare Part A claims.

Respondent avoids the true nature of this case because to recognize that coverage determinations must precede any calculation and collection of an overpayment would be fatal to his position.

The Court of Appeals concluded, and the Respondent does not contest, that 42 U.S.C. § 1395ff(a) requires individualized coverage determinations on all claims for both Medicare beneficiaries and providers. Respondent has not, and cannot, offer any support for the Court of Appeals' mysterious distinction between pre-payment coverage determinations (which the Court finds must be individualized) and post-payment coverage determinations. It is most notable that Respondent fails to reference any statutory authority, for direct or interpretative power, to engage in sample adjudication of coverage determinations.

The language and structure of the Medicare statutory scheme demonstrates that 42 U.S.C. § 1395ff(a) is the

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[1] A critical defect in the formulation of the issue by Respondent is that he presumes the existence of an overpayment without first engaging the mandate process of coverage determinations.

exclusive source of authority for the Secretary's process of issuing coverage determinations. While other provisions establish standards for coverage (e.g. 42 U.S.C. § 1395y(a)(1)), limitations on liability (e.g. 42 U.S.C. § 1395pp), and the Secretary's power of recoupment (42 U.S.C. § 1395gg), all such substantive authority must be channeled through the process of determination required under 42 U.S.C. § 1395ff(a). As the Court of Appeals correctly held, § 1395ff(a) requires individualized coverage determinations. Respondent is authorized to act solely under 42 U.S.C. § 1395ff(a) and regulations promulgated thereunder, 42 C.F.R. § 405.701 *et seq.*, for the process of issuing the resulting coverage determinations.

Respondent contends that petitioners do not explain why the Act's procedural provisions governing pre-payment coverage determinations extend to post-payment recoupment audits. (Resp. 10). However, it is Respondent who cannot explain the authority for a *distinct process* given the language of 42 U.S.C. § 1395ff(a) which extends to all coverage determinations and sets out the exclusive authority for the determinations process.

Providers have the right to rely upon the finality of a Medicare coverage determination unless it is subject to reopening under 42 C.F.R. § 405.750. Respondent acknowledges that "reopening" of the initial claim determinations was necessary in order for him to assert the existence of any overpayment. (Resp. 5). Respondent's own regulations and instructions clearly state that the rights to individualized claim determinations and appeal which apply when claims are initially adjudicated also apply when that initial determination is reopened and revised. *See* Brief of Amici Curiae, American Hospital Association, *et al.* p. 9. Nevertheless, Respondent allows for the exercise of these rights with only a small percentage of the Medicare claims while acting to affect 100% of those claims. The Court cannot assume the drastic abrogation of important procedural rights without expressed intent.

Remarkably the Respondent's regulations are fully consistent with Petitioners' position, yet these regulations are also ignored by Respondent. For example, "a determination as to whether there has been an overpayment or underpayment of benefits paid under part A, and if so, the amount thereof" is considered an "initial determination" under 42 C.F.R. § 405.704, which was promulgated under the authority of 42 U.S.C. § 1395ff(a), *see* 42 C.F.R. § 405.701(a). If, as correctly held by the Court of Appeals, 42 U.S.C. § 1395ff(a) requires individualized determinations, then the Respondent's overpayment decision must be subject to the same process afforded claims at the pre-payment stage.[2]

The Respondent's recognition that the Medicare Act provides no explicit or implicit authorization for sample adjudication leaves him to justify the elimination of individualized determinations on grounds of administrative burden and convenience. (Resp. 14.) However, Respondent also concedes that all coverage determinations within Medicare, for both beneficiaries and providers, are subject to the same process. (Resp. 10.) If the same statutory and regulatory provisions apply, then Respondent must believe that sample adjudication is allowed for prepayment determinations, a position which is at odds with the Court of Appeals findings; Pet App. 6a.

Further, Respondent's position would justify that abrogation of procedural rights for beneficiaries as well. Given that 42 U.S.C. § 1395ff(a) applies equally to providers and beneficiaries, Medicare would be authorized to ignore the procedural protections designed for beneficiaries, if the determination is rendered on a post-payment basis.

Respondent's claim that individualized determinations are not "feasible" conflicts with a judgement already made by Congress. Congress has already balanced the rights to individualized determinations and appeals in the design of § 1395ff. Respondent concedes that the procedural rights must

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[2] Respondent ignores the fact that payments to providers "shall be regarded" as payment to individuals. 42 U.S.C. § 1395gg (a).

be provided for pre-payment of determinations. Such procedures are equally feasible for post-payment adjudication. The jurisdictional amount in controversy requirements set out in 42 U.S. C. § 1395ff present solid evidence that Congress has balanced the need for administrative and judicial review on individual claims against the burden of affording those rights. It set minimum levels of $100 and $1000 for fair hearings and judicial review respectively, amounts which are to be determined with respect to individual claims.

The claims adjudication process set out in 42 U.S.C. § 1395ff is based on the process prescribed by Title II of the Social Security Act, 42 U.S.C. § 405. This Court has consistently found that Title II requires individualized determinations and appeals. (Amici p.6-7). Likewise, as noted by amici, the Title II and Title XVIII claims adjudication process has been amended numerous times since enactment without "the slightest indication that the Secretary is authorized to adjudicate claims" on a sample basis. Amici AHA, et al. 13-14 fn 16. It is not conceivable that Congress could have established the low thresholds for appeal and intended to allow for sample adjudication without so stating over the last twenty-five years of Medicare amendments to the appeals provisions.

B. Sample adjudication denies petitioners important rights to payment for services.

Throughout this case, both the Respondent and the Courts have failed to recognize the harm brought upon providers and beneficiaries through sample adjudication. It is obvious that sample adjudication deprives parties of individualized notices, determinations and rights of appeal. In addition, sample adjudication directly blocks health care providers from obtaining payment for services.

The right to obtain payment for services is evidenced by Medicare policy which states that a provider can obtain payment from alternative third party payors. Longstanding Medicare policy specifically states that the waiver of liability provision of 42 U.S.C. § 1395pp does not apply to third party payors. A provider determined liable under 42 U.S.C. §

1395pp "may seek payment from a third party payor other than a liability insurer without being subject to recovery action that could occur if it sought payment from the beneficiary." Medicare Intermediary Manual, ¶ 3432.2E; Medicare Home Health Agency Manual, § 262.2E.

Many Medicaid programs and third party insurers cover home health services that are not covered under Medicare. These payors provide coverage secondary to Medicare. With sample adjudication, home health agencies cannot document Medicare noncoverage and bill other appropriate pay sources. While the provider can document the individual claims within the sample, it cannot even identify the claims within the universe that should also be subject to third party billing. The sample adjudication system offers no remedy which would allow providers a means to recover payments due from alternative payment sources since no Medicare coverage determination is issued for the anonymous individuals within the universe. The only way that a home health agency's right to seek payment can be preserved is through individualized determinations.

C. Sample Adjudication renders prepayment determinations a sham.

Respondent contests Petitioner's assertion that sample adjudication turns the guarantee of individualized pre-payment determination into a sham. However, the Court of Appeals' decision offers the complete license for that result. Presumably, each claim of the petitioners was subject to an individualized pre-payment review. However, many months or years after care was rendered and payment made by Medicare, along came sample adjudication which, for all intents and purposes, ignored the original individualized coverage determination. In practice and operation the sample determination was substituted for the actual review performed on the original claim. The individualized determination became a meaningless decision, a sham.

Under the system embraced by the Respondent, a cursory prepayment review can be performed on individual

claims, followed by sample adjudication the very next day. Within moments all the protections established by Congress -- individualized reviews, notice, waiver of liability, rights of appeal -- disappear, replaced by a system the Respondent believes to be the only feasible system, despite choices to the contrary made by Congress. Through this subterfuge, the Respondent simply defeats the statutory due process rights of providers, substituting sample adjudication for the mandated individualized determination.

D. Sample Adjudication is unfair and inaccurate.

Respondent has the audacity to claim that sample adjudication yields fair and accurate results. Resp. 13. In reality, sample adjudication destroys health care providers who have committed no offense and blocks providers from their rights to a fair appeal. It is Respondent's policy and practice to recoup any alleged overpayments calculated from sample adjudication well prior to any opportunity of the provider to utilize rights of appeal. Further, Respondent has closed the doors to administrative and judicial relief by claiming that the "amount in controversy" necessary to establish jurisdiction is based upon the individual claim within the sample, rather than the extrapolated effect of the claim in sample adjudication. As such, Respondent has denied Petitioners access to fair hearings and judicial review where the individual claim did not pass the jurisdictional amount in controversy although far surpassing the threshold through the extrapolated projection.

Petitioners exemplify the unfairness and inaccuracy of sample adjudication. Alburqueque Visiting Nurse Service, after decades of providing high quality home health services, has closed and is in bankruptcy, unable to survive the Respondent's attack and obstructions to due process. Chaves County Home Health Services survived, yet it continues to challenge the remaining claim determinations after nearly seven years. Unrefuted evidence demonstrates that honest home health agencies are driven to ruin by sample adjudication.

Sample adjudication only magnifies the errors of Respondent's agents that seek bounties from innocent

providers who are subjected to unsubstantiated tips of program abuse. Respondent concedes that the coverage determinations issued through sample adjudication were generally flawed, noting that Petitioners "largely prevailed" in the appeals process. (Resp. 4-5.) It is a process which is not only unfair, it simply does not make sense. It is also a destructive practice that Congress has prohibited.

E. Sample adjudication is not a longstanding practice.

Respondent's argument that HCFA Ruling 86-1 is not subject to notice-and-comment rulemaking is based upon a fictionalized account of an alleged longstanding practice.

First, Respondent mischaracterizes Mount Sinai Hospital of Greater Miami v. Weinberger. 417 F.2d 329, modified, 522 F.2d 179 (5th Cir. 1974), cert. denied, 425 U.S. 935 (1976) as "upholding [the] Secretary's use of a sampling post-payment audit to recoup $6.3 million." (Resp. 16.) In reality, no court in Mount Sinai Hospital ever reviewed or addressed the legality of sample adjudication. At best, Mount Sinai Hospital represents an isolated incidence of sampling which took place prior to the enactment of due process protections for providers in 1972 through 42 U.S.C. § 1395pp (d) which accorded providers the same rights guaranteed Medicare beneficiaries and Social Security beneficiaries under Titles II, XVI, and XVIII.

Respondent's statement that sample adjudication "has not been a recurring source of controversy in the sixteen years" since Mount Sinai Hospital is indicative of the fact that sampling is not a consistent and longstanding mode of coverage determinations. With the attention this issue has drawn -- amici represent virtually all of the health care industry -- one would certainly expect a challenge to such practice earlier if such practice had been longstanding.

The provider group amici agree that "sample adjudication is neither a common nor longstanding practice in Medicare claims cases." Brief of Amici Curiae National Association of Rehabilitation Agencies, et al., 19; see also,

Brief of Amici Curiae American Hospital Association, et al., 17-18. Since these groups represent the entire health care industry, it is likely they would be aware of the application of sample adjudication in Medicare claims.

Respondent's assertion that sampling is a longstanding practice is in conflict with the General Account Office which indicated that the Secretary had no sampling adjudication process for Medicare Part A. The Secretary then rejected the GAO's recommendation to develop such a process, stating that "home health agencies have certain rights which would not be available under the [sampling] procedure. AHA Am. App. 2C.

Beyond Mount Sinai Hosp., the Respondent cites several Medicare manual provisions that allegedly pre-date the issuance of the contested HCFA Ruling 86-1.[3] Resp. 16. However, Petitioner believes that these citations reference erroneous dates, since it strains credibility to accept that the GAO would suggest the development of sampling policy in 1986 if one existed since 1975.

If the Court of Appeals factual finding that sample adjudication represents a longstanding interpretation by the Respondent is corrected, it's holding on the Administrative Procedures Act, 5 U.S.C. § 553, claim is without any support.

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[3] The Secretary's first reference to these policies occurred in response to Appellant's Petition for Rehearing And Suggestion For Rehearing En Banc. Despite discovery requests for such information over the years, Petitioners have never been supplied these provisions by the Secretary.

CONCLUSION

This petition presents issues of vital importance affecting fundamental rights under the Medicare program. All elements of the health care industry are affected by the Respondent's use of sample adjudication. Respondent tacitly concurs that the matters at issue in this case are crucial. Accordingly, Petitioners respectfully request that the Court grant review.

Administrative developments with HHS further indicate the need for review of the petition by the Court. HHS is preparing a policy issuance which will implement the policy at issue in this case. It is anticipated that the policy will be released to Medicare intermediaries early this year. When the issuance occurs, the risk of harm to Medicare patients and provider will be magnified exponentially beyond that already suffered by the petitioners. The Court must address these issues now before greater harm can be inflicted.

Respectfully submitted,

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JAN 1992